Implementation of a new health system in Colombia: Is this favourable for health determinants?

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The new reforms of health systems in Latin American countries began in the 1990s as part of wider state reforms, promoted by the International Monetary Fund and World Bank. In Colombia, the new system called National Social Security System for Health (Sistema Nacional de Seguridad Social en Salud, SNSSS) was defined by the Law number 100, approved in 1993 by the Congress. Its regulation is under the responsibility of the Ministry of Health and the National Health System Surveillance Institute (Superintendencia Nacional de Salud SNS) that exerts control over the new system structure.

Different types of institutions of medical care, with strong privatisation and competitiveness were introduced by the new law. To facilitate the transformation of public hospitals into more competitive institutions, the Ministry of Health transformed them into "State Social Enterprises" (Empresas Sociales del Estado, ESEs), and also created a new type of healthcare institution called "Health Solidarity Enterprises, (Empresas Solidarias de Salud, ESSs) to allow communities to organise their own enterprises to provide health insurance to individuals and families. Both types of institutions have the responsibility to administer the resources provided by the government to finance the health care of the poorest groups under the so called Subsidised Regimen (Regimen Subsidiado). These two types of "state" institutions should compete with private groups and enterprises but without having the experience and organisation of private sector.

THE STORY

The inhabitants of Versalles, a beautiful small town of 12 000 inhabitants, located in the Colombian western mountains, decided to change their living conditions of poor health, violence, and underdevelopment. Under the leadership of a rural physician (Henry Valencia) and a priest (Hector Salazar), a process of organising the community, promoting participation, and analysing their situation was started in 1997.¹ Today this town, Versalles, is known all over Latin America and other parts of the world for its achievements in health, peace, and quality of life improvement.² The Versalles Community Participation Committee (CPC) defines its role as "building and looking for all kinds of opportunities for working towards the common wellbeing, utilising our potentialities with compromise" (personal communication).

The local development has improved remarkably in this town, but the most impressive achievement is the empowerment of its community; community capacity building and social capital construction are easily identifiable. Versalles had been recognised by the Pan American Health Organisation (PAHO) as a model of a healthy municipality and of peaceful conditions in Colombia and Latin America.¹ Even though poverty is still present, there are facts that show significant changes in the quality of life and cultural transformations that have occurred during the past 10 years. The following few features illustrate the successful results: violence of all types has been reduced so much that the police chief of Versalles

declared recently: "delinquency in Versalles is zero"; even more, homicides were significantly reduced in the past years, from 22 in 1993 to 1 in 1999,¹ in contrast with the high rates of homicides in surrounding towns and cities of Colombia; severe childhood undernutrition is absent; maternal mortality is one of the lowest in the country; immunisation rates are more than 90%, even when the Ministry of Health and international health agencies have recognised that immunisation rates in the rest of Colombia had suffered serious reduction probably because of the problems with the introduction and functioning of a new health system; a community pharmacy provides drugs at low prices. However, not only in the health sector have the results been positive. In other sectors there have been significant changes: the farmers and peasants had recovered confidence and agriculture is increasing in organised farms; new community enterprises and cooperatives are marketing their products. Basic sanitation has improved through public information and health education despite the absence of governmental investment in water supply and waste treatment plants. The education of children and adolescents is an important factor for parents and authorities and they are working together to increase literacy and improve quality of schools. A new civic culture is present in the new generation of Versalles. The community has developed substantial communication and information technologies and has its own television and radio stations; recently the CPC developed a web page on the internet. But the most important feature from a health promotion perspective, is that health workers of the Versalles public hospital—the main health care provider—are actively involved in local development through committees and intersectoral projects, working with a new approach of development, interlinking agriculture, education, culture, art, ecology, and health. Community wellbeing was the aspired outcome. People from Versalles acquired a new vision of health as an integral and comprehensive approach; "health was no more medical interventions and taking medication" (words of Henry Valencia).

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According to the norms of the SNSSS, the community of Versalles organised in 1994 their own Solidarity Enterprise, ESS, as a cooperative effort and affiliated 87.6% of the population of families from Versalles and surrounding towns belonging to low socioeconomic classes. It was so successful that in 1997 and 1998, it was recognised as the best ESS at the province level and at national level. The transparency in the management of the financial resources as well as the goals in building solidarity and confidence were guaranteed for every body.

This ideal ended last year, when the ministry of health and the SNS, decided to change the requirements for the ESSs,

arguing that there were problems related to their management. They abolished the ESSs that did not have a minimum of 200 000 affiliates and a minimal capital fund of \$US140 000.³ Obviously, the ESS of Versalles could not meet with those requirements. Despite the competence, honesty, and effectiveness of the ESS, supported wholeheartedly by the Versalles participatory processes, the new measures punished the community, abolishing their health cooperative. Versalles ESS was forced to join other ESSs and private enterprises. This was considered by the community as a risk of losing local power and being jeopardised by bigger enterprises. It is clear that the Colombian new health system is promoting the growth of enterprises to form big corporations, not recognising the efforts of poor and small communities. Milio described the same situation in United States.⁴

But there are more, other burdens affecting Versalles health institutions: as the SNSSS requires from the providers of care to itemise every intervention that is to be paid for by government subsidies, some of the usual activities of health workers in community committees and intersectoral projects, are not accepted as health interventions and, consequently, are not recognised for government subsidies. Besides that, in this healthy municipality, as result of the real health promotion and disease prevention orientation of health services, people are demanding less medical interventions, which also implies less money. Injuries attributable to violence are less, therefore emergency care costs less than in other hospitals, and that is another cause for cutting Versalles health resources. As a consequence of all these facts, Versalles health budget from the national and province level has been cut by more than 40%. We can see that the National Health System is organised to punish success in getting a healthier population and the fact that it favours disease oriented practice and health promotion is despicable.

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DISCUSSION

Paradoxically, the Colombian Health System in the WHO 2000 Report of Health Systems Performance,⁵ occupied first place in the world in financial equity, based on a measurement of relative expenses in health care by family. The authors of the WHO study deduce that rich Colombian families spend more money in health care than poor ones, therefore, the system is more financial equitable. But the methodology of this controversial study has been seriously questioned.^{6,7} It is clear that the results of WHO survey are misleading, as the current situation of healthcare institutions in Colombia is very critical and several public hospitals have been closed and others are going in the same direction. The multiple problems of implementing a health reform such as seen in Colombia, exceeds the object of this paper given its complexity and contextual conditions. However, the case of Versalles helps when considering the following points:

1 The new health systems introduced after the reform processes in Latin America and other regions are conceived to introduce market laws for health care. The big private corporations for medical care are being favoured by the Health Systems Reforms in developing countries.

2 Real health promotion theories and practice, as stated in the Ottawa Charter,⁸ are far away from the emphasis on medical interventions that are given priority in health systems oriented towards illness/disease and not to health/quality of life.

3 Community participation initiatives and building community capacity for local development are more difficult in an environment of marketing and competitiveness in the health field.

4 Public health programmes—like immunisations coverage—are deteriorating in many countries, as has been reported by UNICEF.⁹ In Colombia the public health policies and programmes have had a reversal as has been recognised by the Minister of Health and public health workers. Public health programmes have deteriorated probably because the system has been fragmented between many private services and thus it is difficult to have accountability for public health policies and interventions.

5 The poor and excluded communities are continuing to suffer inequities in health because social equity goals are becoming harder to achieve within the new trade and market environment that is dominating health sectors in developing countries

To make practical recommendations to correct so many aspects is very difficult. Regarding the Colombian system, we believe that there is a need to make profound changes and adjustments. But, at the very least, it is important to affirm that the conceptual framework of health promotion should be respected to permit and praise comprehensive interventions that tackle social determinants of health. Rigidity of technocratic management of health care systems should be avoided. Otherwise, the theoretical declarations that health reforms are looking for universal coverage and equity will be mainly rhetoric.

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REFERENCES

- 1 Restrepo EH, ed. *Experiencias de Municipios Saludables por la Paz Colombia*. Santafé de Bogotá: Ministerio de Salud Colombia, Organización Panamericana de la Salud, 1999:11–27.
- 2 Organización Mundial de la Salud. Organización Panamericana de Salud, Secretaría de Salud de México. *Quinta Conferencia Mundial de Promoción de la Salud*. México DF: Estudios de Casos Internacionales, Memoria Institucional, 2000:104.
- 3 Ministerio de Salud de Colombia. *Decreto number 1809 de septiembre de 1999*. Bogotá: Ministerio de Salud, 1999.
- 4 Milio N. *Public health in the market. Facing managed care, lean government, and health disparities*. Ann Arbor: The University of Michigan Press, 2000:35–7.
- 5 WHO. *Health systems performance assessment*. Geneva: WHO, 2000.
- 6 Navarro V. Assessment of the World Health Report 2000. *Lancet* 2000;**356**:1598–601.
- 7 Navarro V, Wait G, Mills A. World Health Report 2000: responses to Murray and Frenk. *Lancet* 2001;**357**:1701–3.
- 8 WHO. *Ottawa Charter for Health Promotion*. Ottawa: Ministry of Health and Social Welfare, Canada and Canadian Public Health Association, 1986.
- 9 UNICEF. *World Children Report 2001*. (cited by Wait G, Mills A). *Lancet* 2001;**357**:1703.